MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
PRIOR AUTHORIZATION REQUEST

RETURN TO:
GTE DATA SERVICES
P. O. BOX 5700
JEFFERSON CITY, MO
65102

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The recipient must be Medicaid Eligible on the date of service or date the equipment or prosthesis is received by the recipient. **SEE REVERSE SIDE FOR INSTRUCTIONS.**

I. GENERAL INFORMATION

1. ☐ INITIAL ☐ CHANGE	PA #	2. NAME (LAST, FIRST, M.I.)	3. DATE OF BIRTH
4. ADDRESS (STREET, CITY, STATE, ZIP CODE)			5. MEDICAID NUMBER
6. PROGNOSIS	7. DIAGNOSIS CODE	8. DIAGNOSIS DESCRIPTION	
9. NAME & ADDRESS OF FACILITY WHERE SERVICES ARE TO BE RENDERED IF OTHER THAN HOME OR OFFICE.			

II. HCY (EPSDT) SERVICE REQUEST (MAY REQUIRE PLAN OF CARE)

10. DATE OF HCY SCREEN	11. SCREENING ☐ FULL ☐ INTERPERIODIC ☐ PARTIAL	12. TYPE OF PARTIAL HCY SCREEN
13. SCREENING PROVIDER NAME	14. PROVIDER NUMBER	15. TELEPHONE NUMBER ( )

III. SERVICE INFORMATION (DO NOT WRITE IN SHADED AREAS) FOR STATE USE ONLY

16. REF. NO.	17. TYPE SERV.	18. PROCEDURE CODE	19. FROM	20. THROUGH	21. DESCRIPTION OF SERVICE/ITEM	22. QTY. OR UNITS	23. AMOUNT TO BE CHARGED	APPR.	DENIED	AMOUNT ALLOWED IF PRICED BY REPORT
(1)										
(2)										
(3)										
(4)										
(5)										
(6)										
(7)										
(8)										

24. DETAILED EXPLANATION OF MEDICAL NECESSITY FOR SERVICES/EQUIPMENT/PROCEDURE/PROSTHESIS (ATTACH ADDITIONAL PAGES IF NECESSARY)

IV. PROVIDER

25. PROVIDER NAME (AFFIX LABEL HERE)

26. ADDRESS

27. MEDICAID PROVIDER NUMBER

28. SIGNATURE | DATE

V. PRESCRIBING/PERFORMING PRACTITIONER

29. NAME | 30. TELEPHONE ( )

31. ADDRESS

32. DATE DISABILITY BEGAN | 33. PERIOD OF MEDICAL NEED IN MONTHS

I certify that the information given in Sections I and III of this form is true, accurate, and complete.

34. SIGNATURE OF **PRESCRIBING PHYSICIAN/PRACTITIONER** | DATE

VI. FOR STATE OFFICE USE ONLY

DENIAL REASON(S): REFER TO FIELD 16 ABOVE BY REFERENCE NUMBERS (REF. NO.)

IF APPROVED: services authorized to begin | DATE | REVIEWED BY SIGNATURE ▶

INSTRUCTIONS FOR COMPLETION

I. GENERAL INFORMATION – To be completed by the provider requesting the prior authorization.

1. Transaction Type – Check INITIAL or CHANGE. If change, enter initial prior authorization (PA) number.
2. Recipient's Name – Enter the recipient's name as it appears on the Medicaid ID card. Enter the recipient's current address.
3. Date of Birth – Enter the recipient's date of birth.
4. Address – Enter the recipient's address, city, state, and zip.
5. Medicaid Number – Enter the recipient's 8-digit Medicaid identification number as shown on the Medicaid identification card or county letter of eligibility.
6. Prognosis – Enter the recipient's prognosis.
7. Diagnosis Code – Enter the diagnosis code(s).
8. Diagnosis Description – Enter the diagnosis description. If there is more than one diagnosis, enter all descriptions appropriate to the services being requested.
9. Name and address of the facility where services are to be rendered if service is to be provided other than home or office.

II. HCY SERVICE REQUEST (Plan of care may be required, see your provider manual)

10. Date of HCY Screen – Enter the date the HCY Screen was done.
11. Screening – Check whether the screening performed was FULL, INTERPERIODIC, or PARTIAL.
12. Type of Partial HCY Screen – Enter the type of partial HCY Screen that was performed. (e.g., Vision, Hearing, etc.)
13. Screening Provider Name – Enter the provider's name who performed the screening.
14. Provider Number – Enter the provider's number who performed the screening.
15. Telephone Number – Enter the screening provider's telephone number including the area code.

III. SERVICE INFORMATION

16. Ref. No. – (Reference Number) A unique designator (1-8) identifying each separate line on the request.
17. Type of Service – Enter the appropriate type of service code for each procedure code.
18. Procedure Code – Enter the procedure code(s) for the services being requested.
19. From – Enter the from date that services will begin if authorization is approved (mm/dd/yy format).
20. Through – Enter the through date the services will terminate if authorization is approved (mm/dd/yy format).
21. Description of Service/Item – Enter a specific description of the service/item being requested.
22. Quantity or Units – Enter the quantity or units of service/item being requested.
23. Amount to be Charged – Enter the amount to be charged for the service.
24. Detailed Explanation of Medical Necessity of the service, equipment/procedure/prosthesis, etc. Attach additional page(s) as necessary. **Do not use another Prior Authorization Form**.

IV. PROVIDER REQUESTING PRIOR AUTHORIZATION

25. Provider Name – Attach a Medicaid provider label or enter the requested provider's information exactly as it appears on the label.
26. Address – If a Medicaid provider label is not used, enter the complete mailing address in this field.
27. Medicaid Provider Number – If a Medicaid provider label is not used, enter the provider's Medicaid Identification number.
28. Signature/Date – The provider of services should sign the request and indicate the date the form was completed. (Check your provider manual to determine if this field is required.)

V. PRESCRIBING/PERFORMING PRACTITIONER

This section must be completed for services which require a prescription such as Durable Medical Equipment, Physical Therapy, or for services which will be prescribed by a physician/practitioner that require Prior Authorization. Check your provider manual for additional instructions.

29. Name – Enter the name of the prescribing/performing/practitioner.
30. Telephone Number – Enter the prescribing/performing/practitioner telephone number including area code.
31. Address – Enter the address, city, state, and zip code.
32. Date Disability Began – Enter the date the disability began. For example, if a disability originated at birth, enter date of birth.
33. Period of Medical Need in Months – Enter the estimated number of months the recipient will need the equipment/services.
34. Signature of prescribing/performing/practitioner – The prescribing physician/practitioner must sign and indicate the date signed in mm/dd/yy format. **(Signature stamps are not acceptable)**

VI. FOR STATE OFFICE USE ONLY

Approval or denial for each line will be indicated in the box to the right of Section III. Also in this box the consultant will indicate allowed amount if procedure requires manual pricing.

At the bottom, the consultant may explain denials or make notations referencing the specific procedure code and description by number (1 thru 8). The consultant will sign or initial the form.